DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

November 15, 2018

The Honorable Robert L. Wilkie
Secretary, U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420

Dear Secretary Wilkie:

In order to further strengthen VA's national leadership in health professions education, it is with great pleasure that I submit the minutes from the National Academic Affiliations Council's (NAAC) meeting held in Washington, DC on September 17-18, 2018. The Council respectfully forwards four recommendations, summarized below, for your consideration.

1. Recognizing the critical importance of VA's electronic health record (EHR) modernization efforts, the Council recommends the establishment of a NAAC subcommittee to further examine EHR implementation, provide feedback on the Cerner platform's effects on VA's educational and research missions, and facilitate additional input from VA's academic partners.

2. Applauding VA's central role in Puerto Rico's overall health care system, the Council unanimously endorsed the NAAC Diversity and Inclusion Subcommittee's recommendation to expand training opportunities in Puerto Rico and disseminate some of the unique cultural attributes of the Puerto Rico programs more broadly.

3. Noting the transformational potential of several provisions of the MISSION Act, including the Veterans Healing Veterans scholarship pilot program, the Council recommends that VA seek legislative relief to extend this pilot across at least four entering medical school cohorts. In the absence of such relief, the Council recommends that VA use existing scholarship authorities to extend the program's timeline.

4. Emphasizing the importance of electronic datasets to VA's industry-leading telehealth programs, the Council recommends the establishment of a cross-cutting expert panel to further enhance telehealth's educational potential and address cross-facility and cross-state consultation and supervision issues. The Council felt that a neutral convener, such as the National Academy of Medicine, would be an ideal locus for this task.

We look forward to your feedback.

Sincerely,

Malcolm Cox, MD (Chair)
VA National Academic Affiliations Council

U.S. Department of Veterans Affairs (VA)
Federal Advisory Committee
National Academic Affiliations Council (NAAC)
Meeting Minutes for September 17-18, 2018

VA Central Office
4th Floor Conference Room (4040)
811 Vermont Ave
Washington, DC 20420

The National Academic Affiliations Council (NAAC) met face-to-face on September 17-18, 2018 at the VA Central Office. A quorum was present, affording the Council an opportunity to conduct normal business.

Attendance: See Appendix A

Day 1: September 17, 2018

Welcome and Announcements

Mr. Trynosky called the meeting to order at 8:29 AM EST. Dr. Cox introduced the areas of focus for the meeting, including the latest VA efforts to improve Veteran health care through the VA MISSION Act (Public Law 115-182). The Office of Academic Affiliations (OAA) will be elevated in the Veterans Health Administration hierarchy and report to the newly established Office of the Deputy Under Secretary for Health for Discovery, Education, and Affiliate Networks. This organizational change reflects a long-standing recommendation of the Council. The new reporting relationships are still being developed and will be further refined upon the arrival of the new Chief Academic Affiliations Officer.

Update on NAAC Recommendations from Prior Meetings

Dr. Cox announced that the minutes for all previous NAAC meetings were up to date. Dr. Sanders provided the Council with a brief overview of the recent NAAC recommendations concerning staff time reporting, showcasing the OAA geo-mapping effort for minority serving institutions (MSIs), and the need for a centralized VA matching system for Advanced Fellows. Mr. Duval said that he was struck by the similarity between the agendas of NAAC and NRAC when it comes to workforce development.

During the July meeting, the NAAC endorsed the three recommendations from the Strategic Academic Affiliations Council (SAAC).

Update on VHA Electronic Health Record Modernization

Dr. James Breeling, Director of Bioinformatics within the VHA Office of Research & Development (ORD), presented an update on VHA's Electronic Health Record Modernization (EHRM) project. EHRM is a joint project of the Department of Defense (DoD) and VA. Both agencies will utilize the Cerner EHR platform to achieve an integrated electronic health record. Interoperability is the key aim of this project. This interagency

collaboration is of great interest to Congress and the EHRM will also focus on interoperability between VA, its academic affiliates, and clinical partners.

VA is currently in Phase 1 of the EHRM process identified by Cerner and this includes a pilot implementation in the Pacific Northwest. DoD spent considerable time implementing its pilot in the Pacific Northwest and then paused it to correct issues identified before continuing the EHRM rollout to other regions. VA will probably follow that same geographic EHRM pilot deployment as DoD. Mr. Duval asked if DoD's pilot sites in the pacific Northwest were operational and stable. Dr. Breeling explained that while VA does not have full visibility of the situation, there were some 8,000 "trouble tickets" that DoD and Cerner are addressing.

VA has a pilot period to review the Cerner workflows implemented by DoD and can customize them for VA during this window. Dr. Cox said that the composition of the groups reviewing these workflows is critical because they must raise the right questions. He asked Dr. Breeling if there was any concern within the VA EHRM about having the right people represented, and Dr. Breeling said there was. If the review groups request modifications for things that will delay initial EHRM operating capability, it will be very problematic.

Mr. Duval said that more than likely there will be several Cerner releases and updates, and asked if DoD and VA had a standardized methodology to deal with these. Dr. Breeling answered that there is a separate governance structure for the two agencies. Mr. Duval said that he has heard a bit of uncertainty about the experience of other institutions with Cerner and capturing the unique clinical features of graduate medical education (GME) programs and health professions trainees. Ideally, VA affiliates might be able to inform the EHRM team about what they've been able to capture in their existing workflows. Dr. Breeling said that Cerner is open to a cooperative research and development agreement (CRADA) with VHA. Dr. South-Paul said that the need exists for a substantial number of VA and affiliate clinicians to work with Cerner and create a product that is useful for VA and improves Veteran care.

Dr. Breeling outlined the specific issues raised by OAA and VA affiliates that the EHRM is currently focused on: remote access, identity access management, and hand off tools. Dr. Cox asked if it would be helpful to have a NAAC subcommittee or a joint subcommittee with NRAC to interact with academic affiliates about the EHRM effort and involve them in the process. Mr. Trynosky said that the NAAC established a VHA Modernization Subcommittee in January 2018 and this currently dormant panel could be populated quickly for this purpose. Dr. Prescott asked if medical history related a Veteran's military services will be included in the new EHR, and Dr. Breeling confirmed that it is a central goal of the project. Dr. Prescott also inquired if the EHRM team was looking to ensure that the new EHR platform does not disincentive clinicians and affiliates from partnering with VA. Dr. Breeling said that the EHRM team is trying to collect information on the success of other major EHR transitions in a scientific way that contributes to the field.

Mr. Duval noted that there is a wealth of knowledge about EHRM best practices and much of it was hard-won by learning from past mistakes. VA needs to harvest expertise and prior learning of past Cerner implementers. Dr. Cox asked Dr. Breeling if his team felt that it has tapped the right people to provide support for the problems raised by the Council, and Dr. Breeling said that he felt that was the case. If a NAAC subcommittee is established to focus

on EHRM, the selection of members needs to be focused and the Council should specifically identify experts informed about where EHRM installs have gone well or struggled. Dr. Kellermann affirmed that he has heard reports of implementation challenges with the Cerner system at DoD sites in the Pacific Northwest. He urged close and frequent dialogue with DoD to ensure improved implementation. Dr. Cox asked how VA and DoD interact at the operating level and said that it is very important to get input from DoD employees who are on the frontlines of the initiative. Dr. Breeling said that he did not know of any existing mechanism for operational level information exchange between frontline VA and DoD clinicians.

Recommendation 1: VA's Electronic Health Record Modernization (EHRM) project is critical to ensuring high quality care for America's Veterans. Fully incorporating the expertise and experience of VA's education and research communities, especially the existing experience of its academic partners with the Cerner platform, will greatly benefit this effort. Accordingly, the Council recommends the establishment of a NAAC subcommittee to provide input into the overall EHRM project; this expert panel should also include members from the National Research Advisory Council (NRAC), the Department of Defense, and academic affiliates with experience in large scale electronic health record adoption.

Dr. Cox said that the Council will solicit its membership for the names and contact information of target individuals in the Cerner academic community for Dr. Breeling, and Dr. Kellermann will do the same within DoD. Dr. Cox concluded the discussion by agreeing with Dr. Breeling that this effort is "too big to fail."

Diversity and Inclusion Subcommittee Update

Dr. South-Paul provided a summary of the Diversity and Inclusion Subcommittee's June 2018 site visit to Puerto Rico and its subsequent meetings. The Subcommittee visited the VA Caribbean Healthcare System (VACHS), a unique VA system that faced undue hardship following Hurricane Maria. In addition to visiting the main VACHS campus in San Juan, the Subcommittee went to the University of Puerto Rico and travelled to Ponce, which has the largest Community Based Outpatient Clinic in the region. Unlike much of the continental U.S., where an average of 40% of eligible Veterans receive care from VA, the unique contributions of VACHS and its academic affiliates to overall population health in Puerto Rico increases that number to 70-80%. Trainees who participate in the academic programs sponsored by VACHS are more likely to stay and serve in the region, which speaks to the issue of workforce recruitment, enhancement, and retention. The VACHS' culture of clinical care and its role in creating a supportive and cohesive learning environment was particularly noted by the Subcommittee.

Dr. Edgar Colon Negron noted that one of the most positive aspects of the visit was observing the seamless interaction between one VA system and its four medical school affiliates. Mr. Duval said that the role of the VA programs in sustaining a vibrant physician workforce in Puerto Rico cannot be overstated. Dr. Colon Negron explained that most trainees in Puerto Rico are trying to stay there afterwards and they see VA as an employer of choice.

Dr. Alex Chiu, the Subcommittee's NRAC representative for the site visit, said that he had never seen a stronger sense of trainee ownership in a VA health care system. Dr. Cox asked if there could be VA mentors based on the mainland for VACHS trainees to broaden the availability of advisors about research opportunities. Dr. Chiu said that ORD prefers to have local mentors, but it might be able to find a way to have distance mentors by modifying existing guidelines.

Dr. South-Paul discussed several ideas related to improving the diversity of the workforce pipeline in VA. Dr. Cox appreciated the Subcommittee's suggestions, but expressed concern about how VA can operationalize and prioritize several of them. Mr. Duval agreed that the larger idea is to codify a standing place on the NAAC's agenda to continue this discussion and populate it with informed individuals. Dr. Cox asked the leaders of OAA and ORD to select one or two areas for further development, and suggested that SAAC could weigh in on this as well.

Recommendation 2: The Council applauds the Diversity and Inclusion Subcommittee's June 2018 site visit to the VA Caribbean Healthcare System (VACHS) and the valuable report it provided on VA's robust academic affiliations network in Puerto Rico. In addition to VACHS' vital contribution to Veteran healthcare, the NAAC notes its unique role in public health more broadly in Puerto Rico. Based on the site visit team's observations and conclusions, the Council strongly recommends that VHA expand the unique training attributes in VACHS's vibrant educational culture to its other partnerships with minority serving institutions.

Discussion with Dr. Carolyn Clancy

Dr. Cox introduced Dr. Carolyn Clancy, Deputy Under Secretary for Health for Discovery, Education and Affiliate Networks. Dr. Clancy opened her remarks by saying that with every new administration, there is a signature initiative, and for this administration it is modernization. Given VA's substantial role in developing the overall U.S. clinical workforce, there is a huge opportunity to evaluate which innovations are working at a time when the expectations for clinicians are changing drastically. Dr. Clancy said that NAAC is a group whose advice, recommendations, and disagreements she will gladly accept.

Dr. Wendell Jones asked her about Secretary Wilkie's view on research and clinical education. Dr. Clancy said that she has heard positive things from him on these missions and that he has a desire to know how VA's current affiliations are working and how to improve them. Mr. Duval mentioned three major forces impacting the educational workforce community: commoditization driven by artificial intelligence; consolidation and corporatization; and democratization. He asked Dr. Clancy about her thoughts on the VA clinical workforce in general, including recruitment and other tactical issues. Dr. Clancy said that VA needs to find a way to embed a trusting relationship between clinicians and patients into its clinical training, and prepare trainees to anticipate a world where change continues at a steady pace. Dr. Maine mentioned Health Care Without Walls, a project that looks at how the infusion of technology and the democratization of care will influence how people will want to receive their care. Dr. Cox said that the VA has an enormous opportunity to

facilitate inter-professional care team creation and functioning, but there is a chronic problem of VA failing to involve its affiliated networks early in the discussion process for educational innovations. The combination of ORD and OAA under the aegis of Dr. Clancy presents an opportunity to replace the inward-looking culture of siloed program offices with a relationship-building culture. Dr. Cox thanked Dr. Clancy for meeting with the NAAC.

Update on Community Care

Dr. Kameron Matthews, Acting Deputy Under Secretary for Health for Community Care, updated the NAAC on VA's Community Care Network (CCN) contracting effort. VA is looking to award its CCN contracts for Regions 1-3 by January 2019 and for Region 4 by February 2019. Based on extensive consultation with DoD experts that have experience managing TRICARE networks, the VA learning curve during this CCN acquisition process was greatly reduced, despite the added complexity of new MISSON Act authorities. Though it has been a difficult path, it has been time well spent and will positively impact Veteran care. Dr. Matthews's said that her office's future plans include an integrated purchasing network between DoD and VHA that will create new ways of purchasing care, but leave the coordination of care and interaction with community partners unchanged. Dr. Cox asked how providers and academic affiliates can be assured that the CCN program will be different than the much-criticized Choice program. Dr. Matthews explained that the MISSION Act contractually requires prompt and accurate payments to providers; furthermore, the contracted third-party administrators (TPAs) will not schedule care or interact with Veterans. The TPAs will now play a typical managed care role while VA assumes the responsibility for care coordination.

Mr. Duval noted that the implementation of an appeals process for claims administration is crucial and asked Dr. Matthews if her office has conceptualized redundancies for this task. Dr. Matthews explained that the contours of the appeals process are still in development, but a pilot program was developed using MCG Guidelines, and it is going well so far. VA expects TPAs in the new CCNs to offer a stronger appeals process with a customer service component. Dr. Cox asked how VA plans to roll out the CCN contracts with the current affiliated networks. Dr. Matthews said that the CCN TPAs are expected to build their networks and work with VA on any gaps. There is a provider education team to conduct outreach and an educational webinar series. VA is also actively meeting with state hospital associations to educate providers. Dr. Breslin asked how Veterans are being educated to use CCN-related technology to interact with VA, and Dr. Matthews clarified that most of these systems are not intended for Veteran access; they are primarily for the transfer of information between facilities and partners. Dr. Harper asked if community health centers would be part of these networks, and Dr. Matthews said that they would.

Update on MISSION Act Provisions Related to Health Professions Education

Dr. Cox introduced Dr. Martin Eason, Senior Advisor in the Office of Academic Affiliations, to provide updates on the sections of the VA MISSION Act that impact clinical education. Dr. Eason noted that March 2017 data showed that VA needed around 1100 physicians, 18% of VA physicians were retirement eligible, and 52% will be retirement eligible by 2027. VA needs more physicians in all specialties, as well as the ability to nationally direct the recruitment for these specialties towards areas with the most need. The main purposes of the MISSION Act's clinical educational sections are to 1) recruit the most qualified people,

2) recruit specialties that VA needs, 3) give VA flexibility in assigning physicians, 4) relieve VA clinicians' medical education debt, and 5) recruit more physicians who are Veterans themselves as well as physicians from underrepresented minority groups.

Section 301 of the MISSION Act concerns a designated health professions scholarship program (HPSP) for medical and dental students. Dr. Cox asked if this was originally envisioned as a pilot project with the potential for expansion to other professions. Dr. Sanders clarified that VA already had the HPSP authority for all professions, but because of a recurring two-year statutory authorization, it was impossible for Workforce Management to give any scholarships for four-year programs. Dr. Cox said that it was important to explain that rationale in external discussions so that it is clear why dentists and physicians were singled out in the legislation.

Section 302 is the Education Debt Reduction Program (EDRP) which increases the amount of debt repayment available for VA employees to $40,000 annually and up to $200,000 over the course of five years. Dr. Harper asked if VA Central Office will allocate a certain number of debt repayment packages to each VA medical center. Dr. Eason said that this funding is allocated at the regional and local level. Dr. South-Paul asked if the money for EDRP was fenced for that purpose, or if it came from operational funds. Dr. Wendell Jones said that in this case, money is fenced specifically for EDRP. Dr. Eason explained that Congress would like VHA Workforce Management and OAA to work closely together.

Section 303, the Specialty Loan Repayment Program (SLRP), was designed to give VA the flexibility to build its physician specialty workforce based on forecasted needs. Through SLRP, VA can recruit physicians earlier in their training when the availability of loan repayment is an immediate concern. SLRP allows VA to predict its specialty physician workforce four years in advance. Dr. Prescott asked about the tax implications of these programs, and Dr. Eason said that the loan repayment is counted as taxable income.

Section 304, the Veterans Healing Veterans scholarship program, was designed as a pilot program to bring more physicians who are Veterans into the VHA clinical workforce. The program will support 18 entering Veteran medical students in the 2020 cohort at nine designated institutions: the five Teague-Cranston medical schools and the HBCU medical schools. Dr. Colon Negron asked about the availability of scholarship opportunities for Veteran students at medical schools at Hispanic Serving Institutions. Dr. Eason said that the addition of additional schools beyond the nine explicitly mentioned in Section 304 would require a legislative fix. OAA is hoping that the program will be expanded to additional schools and additional medical student cohorts.

Dr. Cox reminded the NAAC of its leadership role in securing a statutory extension for the GME expansion program authorized through the Choice Act (Public Law 113-146) and said that is important for the Council to continue to point out flaws in the development of VA clinical education programs. He pointedly expressed his concern that the pilot scholarship program authorized by Section 304 will not work as envisioned because it targets only a single medical school cohort. Ideally, this program should include four successive medical student entering cohorts at each of the nine designated schools.

Recommendation 3: The Veterans Healing Veterans Medical Access and Scholarship Program authorized by the MISSION Act (Public Law 115-182) has the potential to transform VA's pipeline of new physicians who are Veterans. However, the pilot is currently limited to a single entering medical school cohort, which will greatly limit its evaluation. The Council recommends that VA seek legislative relief to extend the pilot across at least four entering medical school cohorts and to additional medical schools. In the absence of such relief, the Council recommends that VA use existing scholarship authorities to extend the program's timeline.

Section 403 provides VA with the limited ability to reimburse for physician resident training time and fund GME activities located outside of VA facilities. This authority builds on the GME expansion authority granted by Congress in the 2014 VA Choice and Accountability Act. The primary focus of Section 403 is to incentivize and create GME programs in underserved areas that are rural or serve Native American populations. Mr. Duval asked about the definition of "rural" for the Section 403 provisions. Dr. Eason explained that Section 401 of the MISSION Act requires VA to develop this definition and that effort is currently underway. Dr. Cox thanked Dr. Eason and said that the Council looked forward to positive reports.

Public Comments

Mr. Trynosky introduced Mr. James Farrell, a U.S. Navy retiree who subsequently had a second career as a medical technologist. In a volunteer capacity, he now drives the VA Central Alabama Healthcare System shuttle bus between the Montgomery and Tuskegee campuses. As a volunteer, he speaks with Veterans about their VA care and he has written letters to the VA Secretary proposing a VA medical academy on the Tuskegee campus. Mr. Farrell advocated the use of DoD providers to augment its clinical capacity, expanded use of scholarships for health professions students interested in VA careers, and the development of a pipeline program targeted towards high school and undergraduate students. His full written statement appears in Appendix B.

Day 2: September 18, 2018

Welcome and Review of Day 1

Mr. Trynosky called the meeting to order at 8:32 AM EST. Dr. Cox summarized the Council's proposed recommendations from the previous day.

Review of VA Telehealth Program and Discussion of Related Educational Issues

Dr. Kevin Galpin, Director of VHA Telehealth, and Dr. Linda Godleski, Director of the National Tele-Mental Health Center, gave the Council an overview of the VA Telehealth Program. Dr. Galpin introduced VA's legal definition of telehealth, which is broad and covers most forms of technology. The operational definition of telehealth, however, is purposefully narrow and covers three modalities: clinical video, store and forward, and home telehealth.

VA does a tremendous amount of telehealth with the primary focus of continuity of care. Dr. Wendell Jones noted that while telemental health was initially seen as a taboo subject, its efficacy is now recognized. Dr. Galpin said that VA's goal is to make telehealth and video an option for every Veteran so they have a choice in the delivery of their care.

Dr. Galpin explained that the large percentage of Veterans receiving VA telehealth care reflects the high percentage of Veterans in rural areas. Infrastructure remains a challenge and VA is working with Federal agencies and other private partners to try to close this technology gap. VA is expanding its tablet program that provides 4G-connected tablets to Veterans without internet connectivity as well as including caregivers in telehealth appointments. Mr. Duval said that because of the scarcity of primary care providers in rural areas, rescue squads and local ambulance services often become primary care providers. He asked if VA had looked at using these community paramedicine and mobile integrated healthcare resources to expand access for Veterans. Dr. Galpin said that he would look into this possibility and Dr. Kellermann explained how a similar DoD pilot is underway. Dr. Colon Negron observed that telemedicine provides an opportunity to deliver culturally-sensitive health care, and Dr. Galpin said that VA has explored setting up care with specialized social networks to help promote healthy living.

There is growing interest in the clinical services community for expanded telehealth options, partly because it can be applied to any specialty. Not every telehealth program impacts accessibility, capacity, and quality, but programs can be selected to target certain needs. Mr. Duval asked if the development of 24/7 access to tele-urgent care would be integrated with or parallel to the broader VA's broader Cerner EHRM strategy. Dr. Galpin shared that that integration is a goal, but how it will look is presently unknown. Dr. Cox asked if Cerner's EHRM representatives are interested in the same strategic vision of VA telehealth, and Dr. Galpin said that he thought that they were. Dr. Cox noted that the Council was particularly interested in an integrated approach to telehealth efforts and EHRM. He offered the NAAC's assistance in prioritizing this goal. Dr. Sanders cautioned that although integration is the optimal solution, there may be unintended consequences from tying the future of VA telehealth to a single proprietary commercial product. Dr. Galpin appreciated these concerns and noted that from his experience quality telehealth integration is achievable with the Cerner EHR platform.

Dr. Prescott shared his observation that the efficacy of telehealth must be validated and cannot be seen as a panacea to VA's clinical access problems without robust evaluation. Dr. Cox echoed these sentiments and remains concerned about VA's ability to fully evaluate telehealth because VA clinical offices are often divorced from the research and education missions. Dr. Godleski said that VA mental health is paired with several of the Quality Enhancement Research Initiatives (QUERIs) and has used the telehealth database to track metrics like hospitalization rates. Dr. Prescott questioned whether every clinical service can effectively be provided via telehealth, and Dr. Galpin clarified that VA does not want everything to become telehealth; however, it wants to make telehealth options available for every Veteran, especially for those who lack access to local specialty care. Dr. Kellermann asked if the DoD and VA were collaborating on telehealth at all, and Dr. Galpin said that the goal is to have a common set of competencies for telehealth. Dr. Cox suggested that Drs. Galpin and Godleski also present their information to the NRAC, with greater emphasis on the evaluation component.

The MISSION Act clarified that VA providers are covered by a single state license to provide telehealth. However, there are still state licensing situations where clinical trainees are not covered. VA is seeking a legislative remedy to fix this statutory gap. Dr. Sanders added that this gap presents a legal liability for VA trainees. Out of an abundance of caution, OAA issued cease and desist guidance to VHA facilities that trainees should no deliver care across state lines via any modality except face to face unless properly licensed in that state.

Dr. Godleski discussed the great complexity of coordinating trainee appointments and issues related to the remote supervision of trainees. As VA examines policy guidance related to trainees and integrated telehealth, she provided the Council with several questions that must be addressed:

- What is telehealth in the context of guidelines for trainees?
- When a trainee is added to the mix between a patient and provider, there are three potential sites, and this creates new issues.
- What is the participating institution? Is it where the trainee came from, where the patient is located, where the trainee is physically located, or all three? Do all three become part of the CLER visits?
- Trainees are appointed at their facilities, but if they see patients out of state via telehealth, do they need to be appointed at all of the sites where patients are located?
- Should there be a maximum amount of telehealth allowed in training?
- Does telehealth require unique separate curricular resources and devoted educational time?
- How do you provide feedback and evaluation to trainees by video? How does this tie in with continuity of care?
- How will reciprocity work with supervising trainees?
- Who will peer-review care, and at what site?
- Some accrediting bodies like the ACGME already allow supervision via phone, and tele-supervision has been approved for psychology on the Hawaiian Islands.

Dr. Sanders said that right now, VA's National Trainee Supervision Policy states that trainees and supervisors should be in the same place, and VA cannot loosen its supervision policy until it is clear that it complies with the accreditation bodies' expectations. Dr. Maine mentioned that Health Care Without Walls issued a recommendation for national licensure, and Dr. Kellermann and Dr. Cox agreed that ultimately that needs to happen. Dr. Breslin suggested that it is important for the NAAC to set out core principles about telehealth. Dr. Cox remarked that this was a task outside of NAAC scope and asked who was going to take the lead on that initiative; perhaps there was a convening authority like the National Academy of Sciences, Engineering and Medicine that could play a role in this.

Recommendation 4: VA's large and groundbreaking telehealth program provides exciting opportunities for enhancing Veteran access to health care and for further developing inter-professional team based care. With this in mind, the NAAC recommends that VA:

a. **Promote a more integrated approach to its telehealth efforts and electronic health record modernization initiative to the greatest extent possible. This stronger integration is essential to streamline scheduling and maximize the rich data collected through telehealth platforms and prevent the fragmented delivery of care; and**

b. **Work with the organized health professions to convene an inter-professional expert body to more fully examine the implications of clinical telehealth programs for trainee education, including but not limited to the complexities of trainee licensure and supervision within and across states. The National Academy of Medicine may be a natural convener of such an expert panel.**

Presentation of USUHS Challenge Coin to Dr. Cox

On behalf of DoD and the Uniformed Services University of the Health Sciences, Dr. Kellermann presented Dr. Cox with a challenge coin from "America's Medical School" to thank him for his four years of service as NAAC Chair.

Short Updates to the Council

For-Profit Educational Institutions

VA employees are subject to a statutory prohibition on relationships with for-profit educational institutions. The current penalty for violating this policy without a waiver is dismissal from VA employment. Dr. Sanders was involved in the development and implementation of a VA waiver process. A pilot of this process was launched and all selected sites successfully implemented it. VA OGC is working with Congress to secure modifications to the current statutory prohibition. Deployment of a VHA-wide waiver process is currently on hold as Congress considers this change. Mr. Duval asked when this legislative change may be enacted and Dr. Sanders said hopefully by the end of the current Congressional session. Dr. Maine asked if this prohibition adversely influenced VA facilities' ability to enter academic relationships with for-profit institutions. Dr. Sanders clarified that the prohibition has always been focused on individual employees, not institutional level relationships.

Strategic Academic Advisory Council (SAAC) Update

Dr. Wendell Jones gave the Council a brief update of the SAAC's recent activities. It had a teleconference since the NAAC's July meeting and will have a face-to-face meeting in January 2019. Dr. Sanders mentioned the national Designated Education Officer conference in August where Dr. Clancy conducted a plenary session with a Q&A period. Dr. Clancy pledged to assist with getting priority issues elevated in the VHA organization. Dr. Cox said that in his experience, VHA leadership is willing to go in the right strategic direction, but these efforts often run aground in the bureaucratic and operational processes. Dr. Jones noted that the SAAC recently had a conversation about the impact of nonprofit research corporations on academic affiliates. The SAAC recommended that an expert panel

be created that includes both SAAC members and successful field experts who have demonstrated best practices working with their local nonprofits and affiliates.

GME Expansion

Dr. Sanders reported on Round V of the GME expansion authorized by PL 113-146 which approved 280 additional positions, bringing the total allocation of new GME positions to 1,055 physicians. Mr. Duval asked whether the allocation incorporates the out-year slots that they will occupy, and Dr. Sanders said that it is different for every location. Dr. Cox said that this is a good program, and his only regret is that it is restricted to GME. Dr. Cavalieri said that his school's relationship with the Wilmington VA Medical Center has allowed for the expansion of existing residency programs and provides team-based care experiences for residents.

Future Meetings and NAAC Membership Update

Mr. Trynosky updated the NAAC about its future meetings and changes in membership. Mr. Duval was approved to assume the role of Chair, effective October 1, 2018, and the memberships of Dr. Cavalieri, Dr. South-Paul, and Dr. Valachovic were extended three years through September 30, 2021. He directed the Council's attention to the biographies of the five new members and two new ex-officio members who will begin their NAAC service on October 1, 2018. The retirements of Dr. Cox, Dr. Paul Cunningham, and Dr. Harper were approved effective September 30, 2018. Dr. Candice Chen, an ex-officio Federal member, recently left the Council upon her departure from Federal service.

Mr. Trynosky said that the Council will still have one vacant member slot. He reiterated the change in schedule for upcoming meetings. There will be a telephonic NAAC meeting the afternoon of December 5, and the target date for the next live NAAC/NRAC meeting is in March 2019. Dr. Cox expressed his and the Council's gratitude to the regular and detailed members of the OAA staff, particularly James Deming.

Additional Recommendations

Dr. Cox summarized the three recommendations from the previous day as well as the two recommendations from the telehealth discussion. Regarding the telehealth and trainee recommendation, Dr. Prescott asked if Council can go back to their respective organizations, and Dr. Cox urged them to talk to their leadership. He suggested that it might be helpful for the Council to have some follow-up discussions and invite people from the various health professions to get a sense of whether they have defined the scope of the problem accurately.

Dr. Cox Farewell and Handoff to Mr. Duval

Dr. Cox introduced Mr. Duval as the new NAAC Chair and outlined his biography. He said that Mr. Duval brings a different perspective as a CEO, not just as an educator, and his appointment will link the NAAC to the daily operations of the VA health system. Mr. Duval thanked Dr. Cox and said that he had a very high bar to reach, but he recognized the expectations and looked forward to working alongside the NAAC and the OAA staff to advance VA's historic clinical education mission.

MISSION Act Section 401 Presentation

Dr. Teresa Boyd, Assistant Deputy USH for Clinical Operations, and Dr. Susan Kirsh, Acting Assistant Deputy Under Secretary for Health for Access to Care, briefed the NAAC on Section 401 of the MISSION Act. Section 401 specifically concerns the process for determining the criteria used to identify "underserved" VA medical facilities. Dr. Kirsh and Dr. Boyd collaborated with HRSA and HHS to form a model that largely aligns with other government agencies yet includes some MISSION Act mandated variables such as wait times and the number of specialties per facility. Medically-underserved facilities are not just a rural issue, and it is not just a geographically rural population that needs to be assessed. The variable of provider-to-patient ratios are weighted more heavily than others and CAN scores, a VA metric used to assess the correlation between resources and patient illness severity/complexity are also utilized. Dr. Cox said that he hoped the Section 401 study team will also explore the need-based redistribution of resources among facilities. He asked how they will work with the field to derive the necessary data sets. Dr. Kirsh said that the onus is on whoever is driving the Section 401 effort in VA Central Office to provide information to the network directors.

Mr. Duval asked how the study will capture the portion of the Veteran populations without access to VA care and implored the need for definitional precision. Dr. Sanders reminded the Council that there is a relationship between the definitions developed through Section 401 and the implementation of Section 403's GME expansion. Dr. Kirsh said that the current model seems to acknowledge that FQHCs and Indian Health Service sites are excellent resident training experiences. Dr. Cox emphasized that the NAAC is excited to contribute to the development of these programs and that the MISSION Act provisions address the obvious need for VA trainees to be involved with non-VA patients. Dr. Sanders said that there are creative ways to approach this issue, such as developing gradations of underserved populations. Mr. Duval suggested looking at the issue of who may not be getting captured in the existing data sets. Dr. Cox recommended that the Section 401 team also meet with Dr. Jones and the SAAC.

VHA Office of Rural Health

Janice Garland, Health Systems Specialist from the Office of Rural Health (ORH), spoke about her office and its initiatives. She outlined VA's rural health care challenges and explained the definition of "rural" by Rural-Urban Commuting Area (RUCA) standards. Dr. Sanders added that 95% of VA Medical Centers are in health profession shortage areas (HPSAs). VA is the primary source of care for many rural Veterans, who tend to make less money than their urban counterparts. The Veterans Rural Health Advisory Committee (VRHAC) identifies challenges that rural Veterans face and provides the ORH with guidance and support for its recommendations. Dr. Prescott asked if the NAAC members knew any of the VRHAC members, and Dr. Cox said that an attempt to get to know VRHAC is underway because of the MISSION Act Section 403 authorities. Dr. Maine said that many rural areas have community colleges that can be part of VA's clinical workforce pipeline. Dr. Cox shared his concerns about how many VA programs and offices overlapped, and noted that the focus must be on coordinating these programs and providing care in an integrated fashion. Ms. Garland said that their office does a lot of partnering, and ORH is working on a faculty development program with OAA. Dr. Sanders suggested that ORH's expertise could

assist Dr. Boyd and Dr. Kirsh in helping with the development of Section 401 criteria. Ms. Garland agreed.

HBCU Week Conference Report

Dr. South-Paul updated the Council on the White House sponsored HBCU Week conference panel that she and several OAA leaders participated in on September 18, 2018. The panel participants spoke about VA initiatives to enhance health professions education and research activities with HBCUs. There was considerable interest from the audience members in the OAA geo-mapping project led by Dr. Kenneth Jones. Other interest centered on leveraging VA as a Federal resource to link training programs and pipeline programs. Several stakeholders also highlighted the need for conduits to receive timely information from VA about programs and funding. Overall the HBCU Week conference was a timely opportunity, and it gave the OAA and NAAC representatives ideas about new areas to consider. Dr. Cox thanked Dr. South-Paul and reiterated that just as offices within VA tend not to communicate, communication between Federal agencies can be even worse. Mr. Trynosky asked Dr. South-Paul if a Diversity and Inclusion Subcommittee call would be beneficial before her October 10, 2018 meeting with the SAAC. Dr. South-Paul said that a conference call would be helpful.

Adjournment

Dr. Cox adjourned the meeting at 2:05 PM EST.

Appendix A: Attendance Records

Council members present:
Malcolm Cox, MD, (Chair), Retired Federal Executive, Department of Veterans Affairs; Eileen Breslin PhD, RN, FAAN, President, American Association of Colleges of Nursing (AACN); Thomas A. Cavalieri, DO, FACOI, FACP, AGSF, Dean, Rowan University School of Osteopathic Medicine; Edgar Colon Negron, MD, FACR, Professor, School of Medicine, University of Puerto Rico; John Duval, MBA, Senior Scholar, Accreditation Council for Graduate Medical Education; Doreen Harper, PhD, RN, Dean, School of Nursing, University of Alabama at Birmingham; Wendell E. Jones, MD, MBA, FACP (Ex-Officio), Chief Medical Officer, VA Heart of Texas Health Care Network; Arthur Kellermann, MD, MPH (Ex-Officio), Dean, F. Edward Hebert School of Medicine, Uniformed Services University of the Health Sciences (USUHS), U.S. Department of Defense; Lucinda Maine, PhD, RPh, Executive Vice President and Chief Executive Officer, American Association of Colleges of Pharmacy (AACP); John Prescott, MD, Chief Academic Officer, Association of American Medical Colleges; Karen Sanders, MD, (Ex-Officio), Acting Chief Officer, Office of Academic Affiliations; and Jeanette E. South-Paul, MD, Chair, Department of Family Medicine, University of Pittsburgh;

Council members unable to attend:
Paul Cunningham, MD, Dean Emeritus, East Carolina University School of Medicine; Richard W. Valachovic, DMD, MPH, President and Chief Executive Officer, American Dental Education Association; and Leslie Wiggins, RN, MBA, FACHE, (Ex-Officio), VISN 7 Network Director.

VHA Office of Academic Affiliations staff attending:
Jemma Ayvazian, DNP, ANP-BC, AOCNP, Clinical Director, Nursing Education; Brent Bennett, Budget Analyst; James Deming, Strategic Initiatives Specialist; (Alternate Designated Federal Officer for the NAAC); Christopher Clarke, PhD, FACHE, VHA-CM, Chief Fiscal and Informatics Officer; Martin P. Eason, MD, JD, Senior Advisor; Larissa Emory, PMP, CBP, MS, Health Systems Specialist; Dean Giacobbe, MD, GME Affiliations Officer; Stuart C. Gilman, MD, MPH, Director, Advanced Fellowships and Centers of Excellence in Primary Care Education; Debbie Hettler, OD, MPH, FAAO, Clinical Director; Kenneth Jones PhD, Director, Associated Health Education; Ramona Joyce, Executive Officer; Kathleen Klink, MD, FAAFP, Acting Chief Academic Affiliations Officer; Deborah Ludke, Health Systems Specialist; Monica Lypson, MD, MHPE, Director Medical & Dental Education; John Sharpe, FACHE, VHA-CM, VA-DOD Liaison and Program Manager; and Stephen K. Trynosky, JD, MPH, MMAS, Staff Assistant (Designated Federal Officer for the NAAC).

VA and VHA staff attending:
Ajay Dhawan, MD, FACHE, Chief Medical Officer, VISN 7; Fungchow (Alex) Chiu, PhD, Senior Program Manager, VHA Office of Research and Development.

Guest Presenters:
Teresa Boyd, DO, Assistant Deputy Under Secretary for Health for Clinical Operations;
James Breeling, MD, Director, Bioinformatics, VHA Office of Research and Development; Carolyn Clancy, MD, MACP, Deputy Under Secretary for Health for Discovery, Education and Affiliate Networks; Kevin Galpin, MD, Director, VHA Telehealth; Janice Garland, MPH, Health Systems Specialist, VHA Office of Rural Health; Linda Godleski, MD, Director, National Telemental Health Center, VA Office of Telehealth; Susan Kirsh, MD, MPH, Acting Assistant Deputy Under Secretary for Health for Access to Care; Kameron Matthews, MD, JD, FAAFP, Acting Assistant Deputy Under Secretary for Health for Community Care.

Members of the public attending:
Ulyana Arzamasova, American Association of Critical-Care Nurses; John Ashley, Legislative Aide (Majority Staff), U.S. Senate Committee on Veterans' Affairs; Julie Crockett, American Association of Colleges of Osteopathic Medicine; James Farrell; Jenny Kim, Jefferson Consulting Group; David Keahey, Chief Policy and Research Officer, Physician Assistant Education Association; Colleen Leners, American Association of Critical-Care Nurses; Nicole Lighthouse, American Association of Colleges of Osteopathic Medicine; Kristy Park, Jefferson Consulting Group; Gregg Pone, Association of American Medical Colleges; Tyler Smith, Government Relations Manager, Physician Assistant Education Association; and Cathy Wiblemo, Vietnam Veterans of America.

Court Reporter: Cristina Allegra Chilstrom, Neal R. Gross & Associates

Appendix B: Public Comment

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September 19, 2018

Stephen K. Trynosky, JD, MPH, MMAS
Strategic Initiative Manager
Veterans Health Administration
Office of Academic Affiliation
811 Vermont Avenue, NW
Washington, District of Columbia

Dear Sir;

First and foremost, I would like to thank you for inviting me to the council meeting. This letter will recap my observations of medical treatment at our nation's Veterans Healthcare Systems and possible solutions.

The problems are obviously many. The topics addressed at the meeting coincide with those I addressed in my correspondence to the Secretary of the Veterans Administration, the Honorable Robert Wilkie. In brief I stated there are gross shortages of Independent Healthcare health care professionals/providers within the Veteran Healthcare system. This prompted me to suggest solutions that would seem to serve everyone's needs. My first plan was to allow active duty and reserve medical personnel of the Federal forces (Army, Navy, Air Force, Coast Guard, and, as Dr. Shulkin suggested, Commissioned Corps Public Health Service officers) to rotate within their shore/sea assignments into a VA facility. This would include physicians (of all varieties recognized by the US government as independent health care providers), nurses, medics, and corpsmen. The rotation would both give the service member a break from their arduous sea and combat duties and allow them to hone their medical skills while serving our vets. The result would be a fully staffed Hospital system (CBOCS, Hospitals, Clinics and Satellite Offices). Such a program would coincide with Dr. Martin Eason's "Veteran Healing Veterans" program. This would provide a smooth integration into advanced training of those Corpsmen and Medics interested in seeking a professional degree. Wait times could be reduced and the government would not have to spend exorbitant amounts of money for private sector coverage. Costs would still be substantial, as provider time would still have to be compensated to agencies sharing the providers, and the supplying agencies would have to be provided with substitute providers so that they could accomplish their own missions.

Dr. Martin P. Eason, MD, JD, has outlined a similar plan with his Mission Act Educational Sections: Section 301 HPSP Scholarship Program (a program that has been in place for ~30 years); Section 302 Education Debt Reduction Program (EDRP); Section 303 Specialty Loan Repayment Program; Section 304 Veterans Healing Veterans Program; and Section 403 Pilot Program on Graduate Medical Education and Residency Program. These programs are a

first steps in addressing the long term goal of establishing a continuous pipeline of Independent Health Care professionals to the VHA.

What if we take this a little further? What about establishing a health services site specifically dedicated to the training of health professionals for the VHA such as that which presently exists in the San Antonio school of health sciences currently operated by the military and staffed by retired/current VA, Military/Government, and Civilian medical professionals? Since such a facility is already in existence, why not simply expand the programs offered to include all Federally recognized health professions and have the VA fund positions to meet its own needs. This provides a continuous pipeline of medical professionals for the military, so why not just expand the professional schools on campus and the number of positions supported to include VA students. This would serve to consolidate services and eliminate duplicate positions (and the associated costs). Their commitment would be 7 years of service (6 – 7 years, the same window Dr. Eason stressed in his lecture); a continuous pipeline of medical professionals for our organization. The contractual commitment with the students should lessen the likelihood of attrition when the candidates are commissioned as health professions officers.

There are opportunities for potential medical school candidates at some of our junior high school and high school that the VHS should investigate. My grandson is currently taking college courses in the 9th grade. The Florida school system is experimenting with introducing college curriculum courses to its 9th graders, if these children maintain the grade point average needed they will graduate high school not only with a High School Diploma but also an Associate Degree for the participating College/University. What if the Veterans Healthcare System initiates or contributes to such a program within the local community? Painting the picture creates the desire. Think of it the first two years of pre-med out of the way in high school. There would be a reduction in educational cost and an increase in student who would most likely complete a medical program.

Last, the committee must change its train of thought to fill the gap of this critical crisis. We must first gather statistics, which you have done, noting the shortages at the various facilities across the country. Next establish a recruiting goal, note the shortage then establish an annual recruiting goal, note what you want to achieve for each month and set your tasking to achieve that goal. Recruiting, Augmentation and Retention should be at the top of your list for filling the gap. Recruiting: aggressively gleaning candidates at the rudimentary level of their education noting the advantages and prospects of a medical career. Augmentation: Seek assistance from the Department of Defense to fill the shortage which they would greatly benefit. Retention: find reasonable and plausible means to keep personnel onboard; advancement, bonuses, and retention incentives like the military.

The elephant in the room is still standing, namely, the continuous departure of health care professionals from the VA system due to the abundant and perpetual administrative mismanagement and abuse of the professional staff and serious support staff deficiencies. Professionals must have the same staffing structure as do their civilian (financially successful) counterparts. Until the team of "bean counters" and the professional administrative officers who have not seen a patient in years, but dictate clinical protocol, patient care management, staffing, number of patients seen are relegated to less than total dictatorship positions, physicians and providers will continue be bled out of the system, and the care afforded to our veterans will remain grievously compromised.

I will do everything that I possibly can to support this effort, using the skills I learned in the field as a Canvasser Recruiter for the Navy. Remember I am in the trenches, interacting with

our veterans on a daily bases. I hear their concerns, have cried with them in their despair and comfort their family in their loss. Veterans are dying due to lack of medical healthcare providers and care at our facilities.

Thank you again for allowing me to attend this meeting, looking forward to attending the next and working with you and Mr. Duval.

Respectfully,

James M. Farrell, BS/BA, MPS, PHM